IOWA: Dental Hygienist Public Health Supervision Reporting Form

Dental Hygienist Name: _____

Supervising Dentist Name: _____

Beginning Service Date: _____ Ending Service Date: _____

Public Health Setting: (Check one)

☐ School
☐ Head Start
☐ Federally Qualified Health Center
☐ Public Health Dental Van
☐ Free Clinic
☐ Nonprofit Community Health Center
☐ Federal Public Health Program
☐ State Public Health Program
☐ Local Public Health Program

Clinic/Location Name or Service Site: _____

Address: _____

_____

_____

Service Provided	Total Number Provided	Total Number Clients Served Ages 0-20	Total Number Clients Served Ages 21+	Total Hygienist Hours
Sealant				
Prophylaxis				
Assessment/Screening				
Fluoride varnish application				
Education				
Other (please specify)				

Referral to Dentist(s)	Clients Age 0-20		Clients Age 21+	
	Regular Care	Urgent Care	Regular Care	Urgent Care

Dental Hygienist Signature: _____

This reporting form must be completed and returned to the Iowa Department of Public Health at least annually. Return to:

Iowa Department of Public Health
Oral Health Bureau
Attn: Public Health Supervision
321 E. 12th Street
Des Moines, IA 50319-0075

1/2005